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Feeling Like Me Again

Citation for published version:

McKean, L., Newman, E & Adair, P 2013, 'Feeling Like Me Again: A Grounded Theory of the Role of Breast Reconstruction Surgery in Self-Image', *European Journal of Cancer Care*, vol. 22, no. 4, pp. 493-502.
<https://doi.org/10.1111/ecc.12055>

Digital Object Identifier (DOI):

[10.1111/ecc.12055](https://doi.org/10.1111/ecc.12055)

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Peer reviewed version

Published In:

European Journal of Cancer Care

Publisher Rights Statement:

© McKean, L., Newman, E., & Adair, P. (2013). Feeling Like Me Again: A Grounded Theory of the Role of Breast Reconstruction Surgery in Self-Image. *European journal of cancer care*, 22(4), 493-502doi: 10.1111/ecc.12055

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Abstract

The present study aimed to develop a theoretical understanding of the role of breast reconstruction in women's self-image. Semi structured interviews were conducted with ten women from breast cancer support groups who had undergone breast reconstruction surgery. A Grounded Theory methodology was used to explore their experiences. The study generated a model of 'breast cancer, breast reconstruction and self-image', with a core category entitled 'Feeling like Me Again' and two principal categories of 'normal appearance' and 'normal life'. A further two main categories, 'Moving On' and 'Image of Sick Person' were generated. The results indicated a role of breast reconstruction in several aspects of self-image including the restoration of pre-surgery persona, which further promoted adjustment.

Keywords: breast cancer, breast reconstruction, self-image, quality of life, grounded theory

Introduction

For most, a diagnosis of breast cancer leads to a protracted period of treatment, involving courses of adjuvant therapy (chemotherapy, radiotherapy, long-term hormone therapy), often preceded by surgery to remove cancerous tissue. In cases where breast conserving surgery would distort the breast shape, where the tumour has more than one site or most of the breast is affected, mastectomy may be recommended (NHS Information Centre, 2011). Following mastectomy, women may choose not to replace the breast, to use an external prosthesis or to have breast reconstruction surgery.

Reconstructive surgery may be conducted at the same time as mastectomy (immediate reconstruction), which offers cost effectiveness and a shorter recovery time (Bremner-Smith et al, 1996). Arguably, immediate reconstruction means that women do not have to live with the loss of a breast (e.g. Dean et al, 1983; Stevens et al, 1984; Bostwick, 1995); nevertheless a loss of the original breast still occurs (Hill 2004) and delayed surgery may provide an opportunity to grieve for and accept this loss (Winder and Winder, 1985).

Women who choose to have reconstructive surgery are typically married, younger and of higher socio-economic status (Rowland et al, 2000; Harcourt and Rumsey, 2001; Frierson and Andersen, 2006). Practical reasons, such as not having to use an external prosthesis, and emotional reasons, including the need to feel feminine and sexually attractive, have been cited as motivations for surgery (Reaby, 1998; Querci della Rovere, 2004). Perceived pain or discomfort, fear of appearing vain, a sense that the surgery is not crucial to wellbeing and a wish to avoid unnecessary anaesthesia are possible disincentives (Reaby, 1998; Harcourt and Rumsey, 2001).

Overall quality of life has been found to be the same between mastectomy-only and breast reconstruction groups (e.g. Lee et al, 2009), though other reports indicate that women who have reconstruction surgery have more positive feelings about their bodies, less sexual dysfunction and greater self-esteem (e.g. Dean et al, 1983; Mock, 1993; Pusic et al, 1999; Nano et al, 2005; NHS Information Centre, 2011). However, contradictory results have also been reported (e.g. Yurek et al, 2000) and breast reconstruction does not guarantee that feelings of altered body image are diminished (Harcourt et al, 2003). Some studies have suggested better body image and self-esteem and lower levels of mood disorder in immediate reconstruction surgery cases compared with those who had delayed surgery (Al-Ghazal et al, 2000; Wilkins et al, 2000). However, Harcourt et al. (2003) reported significant improvements in quality of life and psychosocial functioning a year after surgery for both immediate and delayed surgery groups.

Recent research has indicated a relationship between breast reconstruction surgery and sense of normality. Denford et al. (2011) explored the concept of normality within women who were awaiting or had already undergone breast reconstruction surgery. The women considered surgery to relate to normality in: their physical appearance, ability to perform daily behaviours, 'adapting to a new normal' and health status. Therefore breast reconstruction appears to help re-establish a sense of normality by resuming pre-cancer and mastectomy functioning while adapting to a new identity. The aim of the present study was to explore further how breast reconstruction facilitates a sense of normality in terms of both body and self-image, through the development of a grounded theory of the relationships between breast cancer, breast reconstruction and self-image.

Methodology

Design

The study was approved by the local NHS Research Ethics Committee.

Qualitative methods are particularly suitable for looking at patients' experiences and perceived outcomes of plastic surgery (Shauver and Chung, 2010) so grounded theory methodology (Glaser and Strauss, 1967) was chosen for the present study as it aimed to develop a theoretically derived explanation for the effect of breast reconstruction surgery on self-image (Willig, 2001). Constructivist grounded theory was employed as this method acknowledges the need for systematic and deductive analysis, and the role of the researcher's prior knowledge on interpretation (Charmaz, 2006).

Participants were included if they were 18 years or older at the time of breast cancer diagnosis and had undergone breast reconstruction surgery following full or partial mastectomy. Those who had undergone treatment with chemotherapy or radiotherapy within the past three months or had a diagnosis of terminal cancer were excluded.

Procedure

Participants were identified through their attendance at one of three breast cancer support groups run by a local Breast Care Service. Those interested in participating were provided (by the first author, LM) with an information sheet and consent form and were required to opt into the study. Those who returned a reply slip to express their interest in taking part, were telephoned by LM to arrange a suitable interview time. Of those contacted, none refused to take part or withdrew from the study.

Individual, semi-structured interviews were conducted by LM over an 8 week period either at the participant's home or in a hospital clinic room, and ranged in length from 35 minutes to one hour and 5 minutes. An interview schedule was devised around the research aims. Typical questions included: 'What factors were important to you when deciding whether or not to have breast reconstruction?', 'How do you feel breast reconstruction has changed the way you see yourself?' and 'Can you describe the effect that undergoing breast reconstruction had? Digital recordings of interviews were transferred to computerised voice files and transcribed verbatim. Transcripts were made anonymous and all digital recording files deleted. Data were organised using NVivo 8 software (QSR International, 2008).

Data Analysis

Data were analysed in two stages and memos used throughout in keeping with grounded theory. Transcripts were read and re-read by the first author. The first stage of analysis, line-by-line coding (see Table 1), allowed the researcher to become immersed in the participants' stories and ensured that categories were not overlooked. Following initial coding, which fractured the data, axial coding was used to bring the data back together into a coherent whole. At this stage, analysis became more interpretative and centred on theorising about the relationships between categories. The constant comparison of data and codes led to previously identified categories being grouped when conceptually similar, then merged and renamed if appropriate. As interviews and coding progressed, themes already identified were introduced into subsequent interviews. Theoretical sampling is one of the key procedures that underpins the Grounded Theory approach (Charmaz, 2006) and can be described as the task of seeking new data when the emerging theory directs that a new area be

explored further (Glaser and Strauss, 1967). After identifying the core category, selective coding was used, whereby concepts which could not be related to the core category or its subsidiaries were no longer explored. The categories and memos were then sorted into a structure which seemed to best represent and clarify the theoretical relationship between breast reconstruction and self-image. Following analysis, the categories were integrated to create a model of breast reconstruction and self-image (Figure 1).

[Table 1 here]

Ensuring Quality

The third author (PA) cross-checked a number of transcribed interviews annotated with initial codes and memos in order to validate the emergent categories. To keep an audit trail of analysis, the first author kept a record of memos, examples of various coding stages and a diary of her personal reflections on the process (c.f. Dallos and Vetere, 2005). Participant validation was sought from three interviewees, who provided feedback on the themes and model. In acknowledgement of the role of researcher in the research process, the first author had no personal experiences that could have led to the presence of preconceived ideas about breast cancer or reconstruction, but had experience of working with women who have been treated for breast cancer, and witnessed the difficulties associated with accommodating these experiences into their lives.

Results

Ten Caucasian women from three support groups participated in the study. Six had undergone immediate and four delayed breast reconstruction. Ages ranged from 31 to 60 years. The length of time since mastectomy ranged from seven months to nine years (see Table 2).

Analysis generated one core category 'Feeling like Me Again', which was composed of two principal categories 'Normal Appearance' and 'Normal Life'. A further two main categories were identified and entitled 'Moving On' and 'Image of Sick Person'.

[Table 2 here]

Core Category – 'Feeling like Me Again'

The participants expressed that treatment of breast cancer via mastectomy led to a sense of losing not just a breast but other integral parts of their identity:

"I used to look in the mirror and cry every single day..., you know, because well you've lost, you've lost part of you for a start... And not only have you lost your breast, but you've lost so much, like you've lost so many dreams, and you've lost so many hopes, and you've lost... you know, so many things..." (Pt 3)

Breast reconstruction surgery served to facilitate a sense of recovery from cancer. For some, immediate breast reconstruction allowed self-image to be maintained throughout cancer treatment, whereas delayed surgery meant that the disruption to self-image was lengthier, so the role of reconstruction in self-image was more

restorative for these women. Overall the participants felt that the surgery allowed them to feel like themselves:

“After the reconstruction, I was so pleased... you know that I felt so good, and that I was starting to recover and I was starting to get back to... being me.” (Pt 9)

Description of Principal Category – ‘Normal Appearance’

Within the ‘Normal Appearance’ category, themes of ‘Prosthesis’, ‘Clothing’, ‘Femininity’ and ‘Wholeness’ emerged. Concern about physical appearance was paramount for most in choosing to undergo surgery. The immediate reconstruction participants expressed an expectation that they would have felt highly self-conscious about their appearance, and that achieving continuity in appearance was important for adjustment:

“...waking up from the [mastectomy] operation... that would have been a lot more traumatic, had I not had the reconstruction done. In hindsight, it was pretty massive, you know the difference I think, having the reconstruction, waking up from an operation like that, and still having a breast as such, and waking up and not having anything, I think that probably psychologically would have been pretty major for me.” (Pt 1)

This expectation was supported by some of the women who had delayed surgery and reported being extremely distressed by the physical outcome of mastectomy:

“Once I healed a bit [after the mastectomy], I couldn’t look at myself, I was absolutely disgusted, my body image was... Just disgust, absolute disgust in my whole body... I couldn’t look, it was just... horrible, and I never did look, except for that once, I stood and looked in the mirror and I could feel my stomach churning.”

(Pt 2)

A normal appearance was strongly linked with feelings about using a prosthetic breast. Common issues raised were its impracticality and effect on the person’s self-confidence:

“And I didn’t want to keep wearing a prosthesis, there was no chance of that... Cos I was in the garden one day and the prosthesis fell out, that happened twice, and that was embarrassing. There was nobody there, but it fell out... I felt it was degrading wearing that thing.” (Pt 6)

“It’s these awful chicken fillet things that they put in bras, and... there was a very nice lady on the ward who was having her second mastectomy, and she was very nice and she showed me her bras and the little pockets in them, and I just... I felt that that wouldn’t give me the same confidence as having something fixed.” (Pt 10)

In contrast, the participants described how a reconstructed breast felt more like a natural part of the body:

“But I think if you have the prosthesis, it looks the same to everybody else from the outside, but I suppose you’ve always got that worry that it’s not secure, it’s not really part of you, whereas the new breast feels like part of me...” (Pt 5)

Both immediate and delayed reconstruction participants identified that a prosthesis can serve as a reminder of their lost breast:

“It’s a constant reminder I think if you have to put something in your bra every day, whereas if you don’t then..., you’re a bit more free, emotionally and physically...” (Pt 1)

A further constraint on the women’s sense of a normal appearance was feeling limited in their clothing choices. This was due to feeling physically uncomfortable or fearing that others may have been able to see the mastectomy site or prosthesis:

“I couldnae like wear maybe a top to here, cos if I bent forward, you would see it, plus the fact I was flat here... you know it’s really quite flat, well you were flat cos you..., you had nothing there. And with the prosthesis, it would come away from you... I just felt imbalanced.” (Pt 9)

After breast reconstruction, participants felt a greater freedom concerning their choice of clothing. This not only contributed to improved body image but, importantly, allowed the women to wear the same clothes they would have chosen prior to their diagnosis and treatment. Participant 7 who had immediate surgery illustrates this:

“I was still wearing the same clothes, I still just threw my jeans and t-shirt on and away we would go, there was never a big thing about ‘Oh, I haven’t got anything suitable to wear’ or whatever.”

(Pt 7)

‘Normal Appearance’ also encompassed the impact of breast cancer on femininity and how breast reconstruction helped to redress this. Most of the women expressed that their breasts are linked with their sense of femininity and so the loss of one or both breasts through mastectomy compromised this aspect of their identity. For some participants, their personal sense of feminine identity was further significantly challenged by losing their hair following chemotherapy treatment:

“And I think with breast cancer... you’re kind of undermined as a woman... This cancer probably more than any other, strips away at your femininity because you lose your hair, you can lose your breasts, you can lose your ability to have children as well, all these things...” (Pt 5)

“It’s part of your image, feeling like a woman... it’s how you feel, that’s part of you. Without that part of your body you don’t feel

like a woman. And I needed to be that person again, to feel like that again.” (Pt 6)

For immediate reconstruction participants, reconstruction surgery allowed the impact of mastectomy upon femininity to be minimised by maintaining the female appearance throughout:

“Just to have it all done on the one day, and kinda to wake up and be, well, I felt that I was still very much..., looked like a female. So, yeah psychologically for me, that was a huge thing that when I went to the hospital I looked very much the same as I did when I came home.” (Pt 7)

Throughout the interviews was a sense that without reconstructive surgery something was or would be missing. The reconstructive surgery enabled them to feel ‘whole again’, as described by Participant 3:

“I felt more whole again...I don’t know, it’s really hard to explain... You know, you feel more whole again. I think for so long you look down and feel terrible and then all of a sudden it’s gone because of the fact that your boobs are back.” (Pt 3)

Description of Principal Category – ‘Normal Life’

The second principal category concerned the importance of reconstruction in resuming normal daily life and encompassed themes of ‘Day to day activities’,

‘Employment’ and ‘Parenting’. Delayed surgery participants described feeling limited in their ability to undertake and enjoy daily tasks prior to reconstruction, while those who had undergone immediate surgery, like Participant 1, reported the expectation that without reconstruction, their daily functioning would have been negatively affected:

“I definitely would have been more self-conscious about..., baring myself on holiday, on..., even just going shopping I think would be a horrendous experience.” (Pt 1)

An important aspect of the women’s ‘normal life’ was employment. Eight out of the ten participants were employed at the time of their breast cancer diagnosis and treatment. For many, it was important to be able to be discreet about their ill health and surgical treatment, so colleagues would view them as the same person that they had been before:

“I have to think, even the [workplace] I’m at just now, I think they would be shocked if they found out now, because I don’t think they’ll have ANY inkling whatsoever... They just take me for what I am... and I think that’s what saw me through... because I was not this dreadfully ill person. I didn’t have to face a barrage of being asked how I was...” (Pt 4)

“And I felt that, when I would be sitting at my desk, they might be looking, you know just to see if there were any signs...” (Pt 10)

A further aspect of living a normal life was that of parenting. Eight out of the ten participants were parents. They reported that for a mother, especially of young children, the breast is intimately connected to the woman's ability to care for her child and therefore her self- image as a parent:

"I think when you're young and you're, you know you've not long just been breastfeeding your baby, and you know you're all of a sudden going through all this, you're not gonnae have a breast, and it's pretty massive." (Pt 1)

Losing a breast, and the associated change in appearance, was also seen to hamper women's ability to take part in activities with their children. Furthermore, many were apprehensive about looking different from other mothers. There was a belief that immediate reconstruction, in maintaining the woman's 'normal' appearance, would perhaps help children to adjust to their mother's illness:

"Being able to go swimming and the fact that I could still wear the same swimsuit that I'd had before I ever had cancer, you know it's just all normality for the children, so I looked normal and they didn't see me sticking out like a sore thumb. I think it's just that they want their Mum to look like she's always looked, and they don't want to see horrible things like [mastectomies]." (Pt 10)

In addition, it was suggested that reconstruction could help to protect children from unwanted attention and gossip, as they could feel confident that other people would only be aware of the mastectomy if told:

“I think part of that was to protect my daughter as well, cos she was very young, and there was no way I wanted people looking at her and going ‘Oh isn’t it sad, look her mum’s got cancer’... So it was just trying to be normal.” (Pt 3)

Description of Main Category – ‘Moving On’

The participants reported that breast reconstruction had helped them to ‘move on’ in their lives, both in practical (i.e. not having to wear a prosthesis) and figurative terms. This category included the themes ‘Completing treatment’ and ‘Survival’. For many, breast reconstruction was seen as the final phase of breast cancer treatment and so a natural point at which to begin looking forward and planning for the future:

“Once I came home from the hospital, I’d had all my treatments done, I was finished and I had a very positive attitude of ‘Right, that’s me done, I’m fixed, I’m sorted, I can only go forward now’.”
(Pt 7)

Some participants did not view reconstructive surgery as part of treatment, but this did not result in it being any less powerful to the restoration of self-image. A few reported feeling that their new breasts were symbolic of survival, having beaten the cancer, allowing their new lives to begin:

“This is going to sound silly, but my new breasts mean life... like my own breasts meant, well, not death, but pain and suffering, possible death... My reconstructed breasts are about life and living to me...” (Pt 3)

Description of Main Category – ‘Image of Sick Person’

This category included the themes ‘Managing fear of recurrence’ and ‘Control over life’. The participants reported that during breast cancer treatment and prior to reconstruction, their normal appearance or normal life was affected by the appearance of being ‘sick’. Having had a mastectomy would be visible evidence of being sick and different from others. In addition, prior to breast reconstruction, the diseased breast or the mastectomy scars often acted as a reminder or prompt of having had breast cancer. This then led participants to become anxiously preoccupied with the possibility of their cancer returning:

“I mean you’re living... I mean you’re living wi’ it every day, you’re dying every day... I mean that’s how it feels at the time... there’s never a day when you dinnae think aboot it... you wake up in the morning and it’s staring you in the face... that was one of the reasons why I decided to get the, the reconstruction as well, cos it was staring me in the face and I thought ‘well, it might help’.” (Pt 9)

Following reconstruction the participants reported that thoughts of recurrence were less frequent and that they were more able to contain these cognitions and accompanying emotions:

“It used to be the first thing on my mind in the morning and the last thing on my mind at night. It’s not quite so bad now, but still, still there, you know, still a worry. Emotionally it’s..., you can kinda, not forget about it, but you can forget about it more than if you hadn’t had [reconstruction] done...” (Pt 1)

Participants reflected that undergoing breast reconstruction could be seen as an approach to taking control over their life back, allowing them to refute the ‘image of a sick person’:

“You know, again it was all about the control thing I suppose, you know, getting your life back on track again, and... trying not to be reminded, to just look normal .” (Pt 9)

Additional Findings- Barriers

The participants discussed opposition from others and access to services as possible barriers to surgery. Family members were often initially uncommitted to the idea of breast reconstruction, particularly delayed, due to the necessity for further major surgery. Some had experienced very negative comments from acquaintances, suggesting that breast reconstruction is an improper use of NHS resources. They

expressed that attitudinal barriers can be overcome if the woman is clear about her reasoning for undergoing the surgery:

“Everybody was saying ‘Don’t get it done, you’ve been through enough, don’t get it done’, but I wasn’t doing it for anybody else, I was doing it for me, to make me feel better in here (head)... It was mainly psychological, it wasn’t... I just felt better once it was done.” (Pt 2)

A further barrier concerned the variability of access to breast reconstruction services. If immediate reconstruction was not possible, the wait for delayed surgery could be very lengthy and may add to women’s distress:

“I waited 18 months for it and it was absolute hell, I mean it really was... and I honestly feel that if a dog bit your nose off, they wouldn’t make you wait 18 months to get a new nose, and certainly if a man had his willy chopped off, they’d never make him wait 18 months before they put it back on. Maybe it’s not quite the same, but it’s not far off.” (Pt 3)

Model of Breast Cancer, Breast Reconstruction and Self-Image

Findings were integrated to create a model of breast reconstruction and self-image (Figure 1). Three main stages of the breast cancer and reconstruction journey are represented. Perceived barriers were incorporated into the model but do not interact with self-image. During diagnosis and mastectomy, a woman’s self-image is

challenged. She may see herself as incomplete and unfeminine, be confronted with the image of a sick person unable to perform normal activities (parenting and employment). Breast reconstruction facilitates the process of adjusting to and reversing changes to self-image (wider choice of clothing, removing the need for a prosthesis, regained sense of femininity). Concurrently, a woman can reclaim her 'normal life', gain control over her image as a sick person and move on psychologically from treatment.

[Figure 1 here]

Participant validation

The women contacted agreed that the core category and themes reflected their experiences. Additional feedback indicated that the role of breast reconstruction for parenting was also applicable to grand-parenting, and that breast reconstruction's role in signalling the completion of treatment refers to the acute stage of treatment.

Discussion

This study aimed to explore and develop a grounded theory of the role of breast reconstruction surgery in women's self-image following breast cancer. The core and principal categories indicated that surgery had helped women to 'feel like me again', by allowing a normal appearance and life. The importance of 'normality' has been highlighted by other authors (Neill et al, 1998; Nissen et al, 2002; Truelson, 2003; Marshall and Kiemle, 2005; Denford et al, 2011). In the present study, normal appearance was reinforced by not having to use a prosthesis and improved clothing choice, which is consistent with previous research (e.g. Reaby, 1998; Querci della

Rovere, 2004; Frierson and Andersen, 2006; Lee et al, 2010). Furthermore, the participants reported a sense of wholeness following breast reconstruction. Other authors have also described how women seek to restore their sense of wholeness through reconstruction (Berger and Bostwick, 1994; Hart, 1996). Regaining femininity was identified as a key component of a normal appearance. This supports previous research which has indicated that mastectomy may pose a threat to feminine identity (Piot-Ziegler et al, 2010) and that femininity is an important component of self-image after breast reconstruction (Marshall and Kiemle, 2005).

The principal category of 'normal life' described how breast reconstruction had helped the women to recommence their typical daily lives. Not wearing a prosthesis allowed them to feel confident about carrying out typical daily activities and to address the challenge of how to deal with the public presentation of their illness. This role has been discussed by other authors (e.g. Berger and Bostwick, 1994; Marshall and Kiemle, 2005; Querci della Rovere, 2004). Interestingly, the importance of surgery for parenting and employment has received little attention in the literature. Steligo (2005) described how resuming work is an important part of returning to normality but that work colleagues may continue to view women as ill for some time. The participants in this study suggested that reconstruction may help them to avoid this type of reaction by allowing them to be discreet about their treatment. They suggest that breast reconstruction can aid women to resume family life by allowing them to maintain a normal appearance and to exert some control over how their illness and treatment is presented to their children.

The categories of 'Moving On' and 'Image of Sick Person' suggested that breast reconstruction enables women to move on from their cancer experience and treatment, allows them to better manage their image as an ill person and potentially

reduces anxious preoccupation with the fear of recurrence. For some, reconstruction was symbolic of survival. Other authors have noted the role of breast reconstruction in signalling the end of treatment and helping women to move forward from breast cancer (Matheson and Drever, 1990; Berger and Bostwick, 1994; Neill et al, 1998; Nissen et al, 2002). Nissen et al. (2002) wrote that it is unrealistic to expect that breast reconstruction will help women to forget their breast cancer diagnosis. However if prostheses and/or mastectomy scars can act as a reminder of cancer, then it is reasonable to suggest that undergoing reconstruction may help to manage an anxious preoccupation about cancer recurrence.

In the present study, there was very little mention of breast reconstruction's role in regaining or maintaining sexual self-image, though previous studies have indicated that women may continue to experience post-operative sexual anxiety (Marshall and Kiemle, 2005) and that partners can fear damaging the reconstructed breast (Sandham and Harcourt, 2007). It may be that participants did not feel comfortable raising these issues, particularly since single interviews were conducted, whereas multiple interviews may have engendered a greater rapport and openness. It is also possible that matters of sexuality were not foremost for participants, as Luker et al. (1996) found that information about the likely impact of breast cancer upon sexual attractiveness was not a priority for women during treatment. This area requires further research to be better understood, particularly with women who are not in intimate relationships at the time of diagnosis and treatment.

Limitations

Grounded theory requires that theoretical sampling techniques are used in order to develop theory and achieve a saturation of themes. As the available sample

was small, it was attempted to attain theoretical saturation by adapting and tailoring the interview questions as the study developed (Dallos and Vetere, 2005), though true saturation of themes may not have been achieved. As participants opted into the study, there may have been a bias towards those with a positive perspective on reconstruction. The purpose of the study was not to assess reconstruction as ‘good’ or ‘bad’, but to clarify its role in relation to self-image. Nevertheless, it would be of value to test the theory presented in relation to those who had negative feelings towards the surgery, at uptake or post-surgery. The participants in this study were of similar ethnicity, which may limit the generalisability of the findings beyond this cultural group. A number of studies have found cultural differences regarding attitudes to reconstructive surgery (e.g. Kagawa-Singer et al, 1997), though Greenberg et al. (2008) suggest that socioeconomic status may be a stronger predictor of reconstruction uptake than ethnicity. A final limitation was the use of a retrospective design, which may have meant that participants’ reported feelings and experiences at the time of reconstruction were influenced by their current thoughts.

Implications

Potts (2000) states that breast cancer constitutes a “threat to the continuing reality of the self and the body” (p.104). However, there appears to be a paucity of theoretical models relating to the role that breast reconstruction plays in self-image. It is hoped that the theory presented offers a framework in which to understand women’s hopes and expectations for breast reconstruction, the changes that can occur to self-image following mastectomy and further information upon which women can base their decision about breast reconstruction. The theoretical model could also be tested in a larger sample using quantitative methodology.

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Tables

Transcript	Code
Participant: I'm SO happy...	HAPPY about recon
Interviewer: ...that done at the time	
Participant: ...that I had it done, and I'm so happy	
that I had the option to get it done at the time.. em.. I	Happy with IMMED RECON
think it made the whole thing easier for me, in that	Made it easier
when I woke up from the operation, em.. it's quite	
scary to think you've not got a breast anymore, but the	Scary waking up -loss of breast
way that {Breast Surgeon} does it, is he puts a clear	Not so scared

Table 1 Transcript extract: example of open coding

dressing on [<i>Right</i>] and it's just a little bit of tape round	Clear dressing
the scar, white tape, so you can actually see it [<i>Right</i>] ...	Important to see
There's not this big unveiling [<i>Ah, I didn't know that..</i>] ,	Not the unknown
which was.. and I, I actually wrote to him and said that,	Action-wrote letter
you know 'This is a brilliant idea', because I think it	
would have been scarier has it been all covered up and	Covered up=scary
there was a big unveiling of these bandages, you know,	
'What's it gonna look like..?', whereas you could	Need questions to be answered
actually see...	Not hidden

Table 2 Participant characteristics

Part. No.	Age	Relationship status	Timing of reconstruction	Type of reconstruction	Time since reconstruction (years)	Employment status (at surgery)	Prior experience of BC	Current BC health status	Figures
1	35	Married	Immediate	LD Flap	4	Employed	No	Clear	
2	60	Married	Delayed	Implant	9	Employed	Yes	Clear	
3	36	Divorced	Delayed	TRAM Flap	3	Unemployed	Yes	Clear	
4	50	Married	Immediate	LD Flap	8	Employed	No	Clear	
5	31	Married	Immediate	LD Flap	<1	Unemployed	No	Clear	
6	45	Single	Delayed	Implant	2	Employed	No	Clear	
7	44	Married	Immediate	Unknown	8	Employed	No	Clear	
8	40	Partner	Immediate	Implant	4	Employed	Yes	Clear	
9	54	Married	Delayed	LD Flap	8	Employed	No	Metastatic	
10	43	Married	Immediate	LD Flap	3	Employed	No	Metastatic	

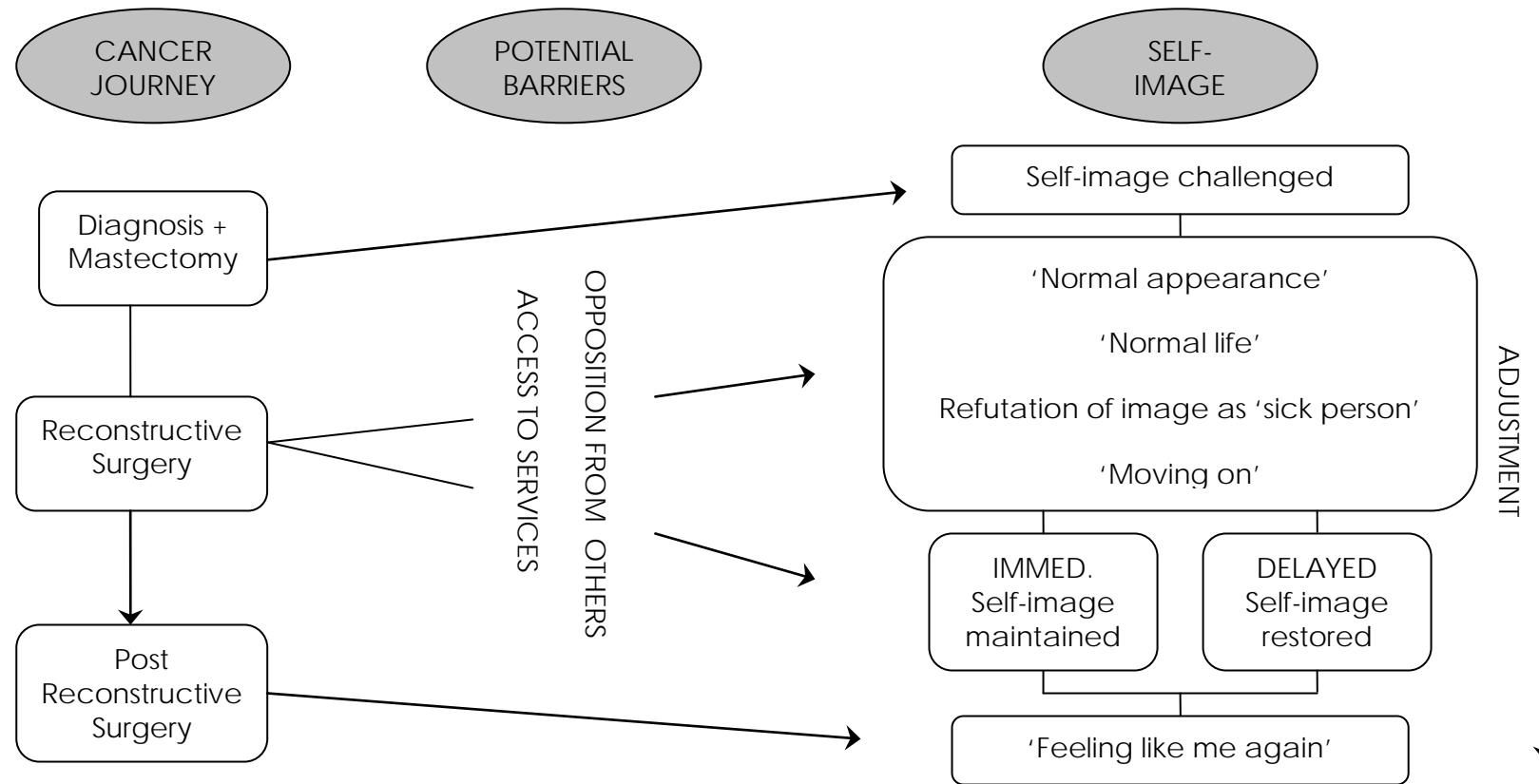


Figure 1 An integrated Model of Breast Cancer, Breast Reconstruction and Self-Image